CIHR—Institute of
Population & Public Health

CIHR IRSC

February 2008
Issue 15

Message from the Scientific Director

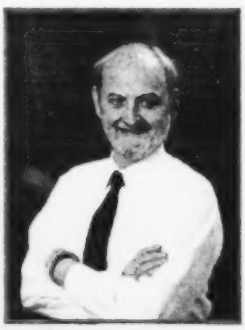
In February 2007 we introduced a new series of profiles on the National Collaborating Centres for Public Health (NCCs), an initiative funded by the Public Health Agency of Canada and actively involving IPPH. In this issue, we are pleased to feature the work of the National Collaborating Centre for Aboriginal Health at the University of Northern British Columbia. We invite you to read the eloquent account of the history, accomplishments and vision of this Centre, written by its Scientific Director, Margo Greenwood.

We would like to congratulate Kate Bassil, a PhD Candidate in Epidemiology at the University of Toronto, and winner of the 2007 Dr. John Hastings award. Kate reflects on being a student in public health and winning this prestigious award.

In this issue, we also feature the work of researchers concerned with nutrition and food security issues. Aleck Olstry, Canada Research Chair in the Social Determinants of Health at the University of Victoria, writes about how lessons from history can be applied to the nutritional policies being developed now in Canada. We are also pleased to present a joint submission from Lynn McIntyre, Professor, University of Calgary and Valerie Tarasuk, Professor, University of Toronto, two self-described "veteran" researchers, who contribute an important essay on household food insecurity in Canada. Specifically, they suggest areas for urgent policy action and make the compelling argument that a living income, rather than food charity, is necessary to mitigate the problems of food insecurity in Canada.

We are also pleased to take this opportunity to update you on our plans to review IPPH's five-year strategic plan. At its retreat in January 2008 members of the Institute Advisory Board deliberated on the institute's strategic priorities. Specifically, advisory board members were assigned on the basis of their expertise and/or interests to one of five working groups responsible for reviewing each strategic research priority outlined in the strategic plan for 2002-2007. Each of the working groups responded affirmatively to support the continuation of the five themes as a priority for IPPH. However, several suggestions were made regarding how the themes could be reframed in the future, including renaming the priority areas. Stay tuned for further updates in the coming months.

In addition, the very successful 6th Annual IPPH and Institute of Health Services and Policy Research (CIHR-IHSPR) Summer Institute, hosted this past year by Dr. Penny Hawe, has released its final report.



You can find this report at the website URL: www.ucalgary.ca/phirc/pdf/CIHR-IPPH-IHSPR_SummerInst2007.pdf Look out for details of the 2008 summer institute focused on knowledge translation.

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Some Final Thoughts

John Frank, Scientific Director, February 2008

As all of you must now be aware, I depart CIHR June 30th to take up the Directorship of a new MRC Unit in Edinburgh, the Scottish Collaboration for Public Health Research and Policy. It is an exciting time in Scotland, and indeed the entire EU – of which the Scots are an enthusiastic new member, now eschewing their representation at social, health and education meetings. Recent trips there have taught me something about the changing times for population and public health (PPH) research and knowledge transfer and exchange, throughout the Western World.

It is now becoming clearer that, to achieve really "critical mass" in population and public health research – especially that which is able to usefully inform public health practice and programs, and "healthy public policies" – one needs more than just traditional operating grants and personnel awards. Specifically, there is an increasing emphasis in PPH research funding in the U.K., and throughout Europe, on Centres, Observatories, and multi-stakeholder consortia (hereinafter referred to as "Centres", for the sake of brevity).

The reasons for this new emphasis are not hard to fathom. Much of the research most relevant to decision-makers, in both the public and non-for-profit sectors that influence the major determinants of health, requires the long-term development of major database-related, intellectual and social "capital" for its successful execution and application. Let's look at each of these factors in turn.

First, the sorts of policy and program intervention opportunities, that usually arise in these two sectors, require promptly-responsive and yet scientifically sophisticated evaluation capacity that runs on a much faster time-frame than traditional investigator-initiated research. Unique chances to robustly demonstrate the effectiveness, unexpected consequences, and efficiency of new programs and policies often arrive on one's doorstep rather suddenly. Access to historical, routinely collected data will therefore frequently be critical to, for example, construct time-series of outcomes across jurisdictions with and without a given intervention. And record-linkage – to vital statistics, disease registries, or health care utilization outcomes – will often be required for rigorous program and policy evaluation. These sorts of capacities usually require many years to develop, often in the contexts of long-term data-sharing agreements, respecting sound legal and ethical principles of confidentiality. These agreements are typically held by publicly funded and university-affiliated "data steward" Centres – of which Canada has notable examples in several provinces.

Secondly, as those who have done this sort of work can readily testify, it requires long-term human resource investments. Record linkage to administrative datasets is frequently tricky, and often it takes years of experience to really master, especially the interpretation of complex findings. To expect the skilled analysts and researchers working with such databases to just be readily recruited from the usual "research associate job-market" is unrealistic. These talented persons need life-long, reliable and rewarding career trajectories and advancement ladders, which in turn implies employment in the sort of Centre that has a critical mass adequate for the task.

Finally, trusting, long-term relationships with key decision-makers are critical to the success of translating such Centres' work into actual policy and program decisions influenced by empirical evidence, including evaluative intervention studies conducted locally. Short-term operating-grant recipients are usually not able to establish and maintain such relationships, especially from within traditional university departments with many other demands on them. Dedicated "edge of campus" institutions, such as Centres with joint multi-stakeholder governance, are essential.

These lessons have been well learned in some parts of Canada – but the existing Centres often live from year to year on the basis of the current provincial government's largesse, and are excessively focused in some cases on short-term research and evaluation questions that dominate provincial decision-makers' agendas. In addition, the PPH research component in some Centres is often in direct competition with the health care services and policy research component, and the latter is often seen as more directly meeting provincial Ministry of Health decision-needs. Thus new ways have to be found to augment the funding of such Centres (including networks of external collaborators with a wide spectrum of disciplinary skills), and to establish new Centres where the region has none, to perform PPH research on the determinants of health, as well as interventions to improve health at the population level, and to reduce inequalities.

Scotland is precisely at this point in the history of PPH research – and I am privileged to lead the new shared-resource MRC Unit designed to facilitate that work. I look forward to many future interactions with all of you in Canada, where I predict the same sort of trend, already underway, will profoundly affect the research enterprise in the coming years.

Thank you to all who have been such supportive colleagues and wise advisors in my seven years plus at CIHR-IPPH. I will miss you all – but it is an ever-smaller world, and we shall meet again.

John

Household Food Insecurity in Canada: A Case where Evidence is neither Necessary nor Sufficient

By Lynn McIntyre and Valerie Tarasuk

As two veteran researchers, with nothing to lose but our impatience to make a meaningful difference in the lives of people in Canada who are experiencing food insecurity (broadly defined as limited access to adequate food), we welcome the opportunity to reflect upon what the evidence tells us. Specifically, where are there gaps in our knowledge base, and where is immediate policy action warranted? The evidence tells us that income-related household food insecurity in Canada is common, dehumanizing, unhealthy, predictable, and preventable. Quite simply, it is a problem of income adequacy. The evidence also tells us that food and feeding programs (e.g., food banks, meal programs, community kitchens, etc.) do little to mitigate the problem. There is a gap in our knowledge about which specific social policy levers drive food insecurity rates up and down, for whom, and by how much. We also don't know why the political will cannot be mobilized in Canada to address at least the most severe problems of food insecurity (i.e., absolute food deprivation).

The 2007 holiday season has once again shown us that food insecurity, popularly called 'hunger', is a top-billed charitable cause. The local Calgary CBC radio show set a target of $700,000 to be raised this holiday season for the food bank. That goal was reached a week before Christmas and so the target was raised to a million. The new goal was exceeded again with $1.1M raised for Calgary's 'hungry'. And through this celebration of charitable giving, the illusion that local problems of hunger had somehow been addressed was again perpetuated. The evidence that we and others have worked so hard to amass, demonstrating that a living income – not food charity - is essential to reducing food insecurity, is ignored in the face of this grand illusion. Our findings are not even disputed or criticized!

To begin tackling household food insecurity, there are two policy imperatives that we would propose. We would first call for a reduction of abject poverty in Canada as a means to deal with the most severe problems of food insecurity. Those most vulnerable are people on social assistance, and improving their lot means increasing social transfers to them. Do it any way you like, through affordable housing, day care, cessation of the clawback by provinces of the National Child Benefit, increase in social assistance rates, heating fuel subsidies—anything that increases income availability for food. Second, we would ask for the establishment of a national monitoring system for income-related household food insecurity, based on the standardized multi-item questionnaire that brought us the compelling results of a 9.2% household food insecurity rate, and a food insecurity rate of 59.7% among social assistance recipients (84% in Alberta!) in the 2004 Canadian Community Health Survey (CCHS) 2.2. By the time CCHS 3.1 was launched, the module had been made optional, and several provinces had opted to omit it. The module has been administered nationally on CCHS 4.1, but it is unclear whether the results will be comparable to those from preceding or subsequent cycles. To understand how policy changes impact food security prevalence, we need to monitor this problem on an ongoing basis.

Unlike so many complex research issues that challenge CIHR researchers throughout Canada, the story of household food insecurity in Canada is pretty straightforward, not that there isn't interesting and important work left to do such as to measure the impact of policy interventions aimed at reducing food insecurity. However, the evidence that we have about food insecurity in Canada has lamentably been neither necessary nor sufficient to galvanize support for the policy changes needed to address this issue.

Please send questions or discussion points about this commentary by e-mail to <lmcintyr@ucalgary.ca> or <valerie.tarasuk@utoronto.ca> .

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Please also take note of our current funding opportunities in this issue.

Plans for the 2008 CPHA Conference are in full swing. The conference will be held in Halifax, June 1-4, 2008 and will focus on "Public Health in Canada: Reducing Health Inequalities Through Evidence and Action". Dr. Michael Marmot will deliver the keynote address. We urge you to participate with us in this always important event. Full details of this conference can be found at:

www.cpha.ca/en/conferences.aspx

I look forward to seeing you in Halifax in June.

Warm regards,

John Frank
Scientific Director

Leading from the People: The National Collaborating Centre for Aboriginal Health at the University of Northern British Columbia

By **Margo Greenwood, Scientific Director**

Tansi,

My mouth waters as I recall summertime when the Saskatoons are plump with juice and sweet to the taste. On warm Sunday afternoons, my Mother would pack up our old '53 Chevy with a picnic basket and blanket along with me and my brothers to go berry picking. We would drive for about an hour which, when you are child, feels like forever. Sometimes other family members were there, but most times we were alone. The fields of parkland brush were home to wild strawberries, Saskatoon bushes and low bush cranberries. Purple mouths and stained fingers were the order of the day. I think sometimes we ate more than we picked, yet those old syrup pail buckets always seemed to get filled. The best though was when Mom would make Saskatoon berry pie -- the taste of it is still in my mouth. I learned a lot on those trips, I learned about the berries, where they grew best, what they would taste like given the weather conditions, but most of all I liked when Mom would tell us stories of the family, of when she was a little girl. It didn't matter that I had heard the stories many times before – I still see those images in my mind. It is from this place of experience and learning that I entered adulthood, Western education, and to here, the National Collaborating Centre for Aboriginal Health, where multiple knowledges work in concert to support a common vision: the health and well-being of Aboriginal peoples.

Since 2005, The University of Northern British Columbia (UNCB) has been home to the National Collaborating Centre for Aboriginal Health (NCCAH), funded by the Public Health Agency of Canada. UNBC, located in Prince George in northern British Columbia, serves a region rich in cultural diversity, including 17 First Nations with more than 27 distinct languages and dialects. From this environment, the NCCAH seeks to support First Nations, Inuit and Métis communities across Canada to realize their health goals and, in doing so, reduce the health inequities that currently exist for their peoples. The NCCAH is one of six National Collaborating Centres (NCCs) each of which is tasked with the goal of strengthening public health in this country. The NCCAH is unique from the other five NCCS because we focus on a specific population (Aboriginal peoples) rather than on a specific subject area.

Our vision, which guides all of the work we do, is a public health system that is inclusive and respectful of First Nations, Inuit and Métis peoples, that reflects their public health needs and aspirations, includes their views in direction and design, and is strengthened by their knowledge. The purpose of the NCCAH is to improve the public health system through a coordinated, wholistic and comprehensive approach to the inclusion of First Nations, Inuit and Métis peoples of Canada. This may include research and Indigenous knowledge in the ongoing development of the public health system in Canada. The NCCAH pursues this mission through knowledge synthesis, translation and exchange and the creation and fostering of links among researchers, the public health community and stakeholders working with First Nations, Inuit and Métis peoples and communities.

One of the most unique aspects of the NCCAH is that all the work we do is guided by a multidisciplinary Advisory Committee comprised of members representing a vast cross-section of Indigenous communities and groups. All members of our Advisory Committee, which include, among others, members of Inuit, Metis, and First Nations groups from coast to coast to coast, are dedicated to the guiding principles of the NCCAH. These principles include:

- respecting the diversity and distinctiveness of First Nations, Inuit and Métis peoples;
- respecting the unique interests, needs and public health issues of First Nations, Inuit and Métis peoples wherever they live in Canada;
- including First Nations, Inuit and Métis peoples wherever and whenever possible in the redesign, direction and operation of the public health system;
- incorporating Indigenous knowledge in all of our activities;
- using collaborative, wholistic approaches that address the determinants of Aboriginal health;
- ensuring all stakeholders have the opportunity to participate in our work;
- developing the capacity of all stakeholders to collect and apply reliable, quality data in their efforts to have a long-term and meaningful impact on the public health system in Canada on behalf of First Nations, Inuit and Métis peoples, and for the benefit of all Canadians; and,
- improve the health status of First Nations, Inuit and Métis peoples across Canada.

Ultimately, these principles and visions guide us in the work we do, including our core strategic directions of:

1. making knowledge synthesis, translation and exchange (KSTE) more relevant to diverse First Nations, Inuit and Métis communities,
2. creating relationships with diverse First Nations, Inuit and Métis peoples, and advance their public health priorities, and
3. continuously evolving the NCCAH's infrastructure and administrative capacity.

With all of this in mind, the NCCAH has been very busy undertaking specific tasks and activities, each of which reflects our goals, visions, and commitments to Indigenous peoples and perspectives.

In partnership with the First Nations Inuit Health Branch, the NCCAH hosted an Aboriginal Dialogue Circle. This pro-

Continued on page 5 ...

New Catalyst Grant

The CIHR Institutes of Neurosciences, Mental Health and Addiction; Population and Public Health; Health Services and Policy Research; Human Development, Child and Youth Health; and external partner organizations are pleased to announce the launch of a new funding opportunity in the area of workplace mental health. The registration deadline is April 15th 2008 and the application deadline is July 15th 2008. This is a Catalyst Grant, designed to support team planning and development activities. Funding will be up to $80,000 for one year.

For further information, please contact:
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Asimina Saikaley (asaikaley@cihr-irsc.gc.ca)

website URL: www.researchnet-recherchenet.ca/rnr16/viewOpportunityDetails

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... NCCAH — continued from page 4

vided individuals and organizations knowledgeable in Aboriginal health with the opportunity to inform the Canadian Reference Group to the WHO Commission. The WHO Commission on the Social Determinants of Health received information and advice that focused on addressing the serious health inequities being experienced by Aboriginal peoples in Canada. The dialogue also provided the opportunity for advancing discussions on policy action for the social determinants of health.

We hosted a Think Tank entitled Evidence & the Social Determinants of Health: Assessing the Possibilities, during which we partnered with the National Collaborating Centre for Determinants of Health (NCCDH). The purpose of the day was to explore the concept of evidence (in an open, constructive and meaningful manner) with public health practitioners, policy makers and researchers. Additionally, we explored the forms, assumptions and benefits of evidence; and discussed how to constructively shape the NCCDH knowledge synthesis and exchange activities.

We supported a Strategy Session on Social Change for Aboriginal Children and Youth Health, led by the Canadian Paediatric Society and the First Nations Child and Family Caring Society. The objectives for the strategy session were to develop a process to identify short-term and intermediate objectives and strategies at the policy, practice, and community levels; and to develop an action plan for sustained improvements to the health and well-being of Aboriginal children and youth. This session is part of the larger Many Hands One Dream movement, which is a "long-term initiative to generate commitment, foster collaboration, and develop and implement solutions that will improve the health of Aboriginal children and youth in Canada. (www.manyhandsonedream.ca)

We co-hosted the Indigenous Children's Rights Regional Meeting with the International Institution for Child Rights and Development (University of Victoria) to support the development of a General Comment on Indigenous Child Rights for the UN Committee on the Rights of the Child. The NCCAH included a particular focus in the general comment on Indigenous childrens' rights as a determinant of health.

These original initiatives will continue through ongoing partnerships and into the future. For instance, work that began in 2007, during which the NCCAH compiled a comparative inventory of the community and public health policies and legislations that are relevant to Aboriginal health will continue. We also conducted case studies on the impact of policy and program delivery in First Nations, Inuit and Métis communities in Canada, including one case study of New Zealand policies that support Māori involvement in regional health care authorities, including learnings that might inform the Canadian context. In 2008, the NCCAH will proceed with the dissemination of the inventory and the case studies to Aboriginal organizations and policy decision-makers.

Furthermore, through partnerships established in 2007 with the Assembly of First Nations, the National Aboriginal Health Organization, First Nations Inuit Health Branch and others, the NCCAH established a First Nations Environmental Health Innovation Network (FNEHIN). Over the next year, the NCCAH will continue to address emerging environmental health issues such as: supporting the work of FNEHIN; disseminating a database of researchers and research projects in environmental health, as well as a series of papers on environmental health issues in First Nations; and hosting an inaugural forum on First Nations environmental health.

We continue to partner with our sister NCCs from across Canada on our annual summer institute that is expanding this year to include others from beyond the centres themselves. In short, the future is bright as we continue to build our relationships and share knowledge.

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Are there Lessons from History for Current Efforts in Nutrition Policy Making in Canada?

By **Aleck Ostry, MA, M.Sc, PhD.;**
Canada Research Chair in the Social Determinants of Health and Michael Smith Foundation for Health Research Senior Scholar; Associate Professor, University of Victoria

Nutrition policy making in Canada has a relatively long history beginning in 1874 with passage of the food adulteration act. In the 1920s, following the discovery of many of the vitamins, the federal department of health built the laboratory and surveillance infrastructure to monitor the increasing volume of vitamin adulteration cases and, also developed a national education program promoting breast feeding (Nathoo and Ostry, in press). In 1938, the federal government established the world's first modern national dietary standard (Ostry, 2006a, 2006b, 2007).

In the 1950s and 1960s food fortification policies were developed and laboratory capacity expanded to deal with new environmental threats to food safety from the growing use of pesticides and herbicides (Nathoo et al, 2005). Dietary standards and guidelines continued to evolve from their Second World War origins although, it was not until the end of the 20th century that national guidelines moved away from their strong emphasis on meat and dairy consumption (Ostry, 2003a, 2003b, 2005, 2006a, 2006b).

There are several lessons from the history of nutrition policy making that may be useful for Canadian policy today. First, in the 1920s, and increasingly through the 1930s, nutrition policy, driven by concerns over malnutrition and, at least throughout the 1930s, by closed international markets for agricultural products, was focused on increasing domestic consumption of meat and dairy products. This was facilitated because the Department of Agriculture was one of the most powerful federal departments particularly relative to the recently formed Federal Department of Health (Ostry, 2006a).

Second, national dietary standards were designed, in the 1930s, to increase animal-based agricultural production and consumption. Nutritional sciences and their role in nutrition policy making originated within the crucible of this agri-economic dynamic. While often not explicit, nutrition policy making has cast an eye towards the economic needs of Canadian farmers and agri-business (Ostry, 2006a). Today the need is for dietary guidelines that increase vegetable, fruit, and fiber intake in the population. Encouragement of consumption of more of these products, because many must be imported and because the agricultural system is not fully oriented to their production, processing, and distribution, may provide less benefit to Canadian farmers and agri-business than the traditional emphasis on the consumption of meat and dairy products.

As well, as Nestle (2002) has pointed out the "eat less" dietary guidance that is now required has potential negative impacts for established agricultural practices and incomes. The lesson from history is that joined-up models of agricultural and nutrition policy making are needed that explicitly link the production with the consumption side of the food and nutritional health equation.

Third, from the 1920s and 1930s to present day, except in the case of food fortification policies, most population-based nutrition policies have been targeted at changing the shopping, cooking, and dietary habits of mothers (Ostry, 2006a). However, even with long-term reliance on these types of policies, there is virtually no evidence that they work. This is a problem particularly because the less well educated members of society, those with the greatest health needs, are usually the least amenable to behavioural change based solely on nutrition education. The historical lesson here is that a much wider and stronger evidence base for population-based interventions to improve nutritional health is needed.

Fourth, while there are few historical instances of direct attempts to "constrain the market" to improve nutritional health, there are some recent examples such as the restrictions on advertising to young children in Quebec and restrictions on marketing infant formula. While the impact of restricted advertising to children in Quebec has not been evaluated yet, there is limited evidence that restrictions on marketing infant formula, beginning in the 1970s, both internationally and within Canada, particularly in hospitals, has helped improve the environment for breast feeding (Nathoo and Ostry, jurisdictions ministries that are currently attempting to constrain the marketing and sale of "junk foods" in schools (Rideout et al., 2007).

Fifth, it is essential that nutrition policy makers seek allies and policy levers outside Ministries of Health (Ostry, 2006a). For example, there is some evidence that while not influencing initiation, the structure of women's employment and access to benefits does affect the duration of breastfeeding (Nathoo and Ostry, in press). Given that Canada now promotes 6 months of breast feeding, and given the clear historical lesson that placing most policy eggs in the maternal education basket is a mistake, it is essential that the Employment Insurance System, and provincial employment ministries are drawn into any nutritional policy discussions to increase the duration of breast feeding.

Finally, attempts were made in the late 1970s, as food price inflation rapidly worsened, to develop both conceptual models and policy frameworks and capacity to cross the agricultural/nutritional health policy divide. However, once the inflationary crisis faded these efforts to create a joined up food and nutrition policy making infrastructure at the federal level faded. As Riches et al (2004) note, if ever there was a time to re-visit these efforts from 30 years ago, it is now.

References follow, on page 7.

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KATE BASSIL — RECIPIENT OF THE 2007 "DR. JOHN HASTINGS AWARD"

PH.D. CANDIDATE, EPIDEMIOLOGY
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My interest in public health research and generating evidence with practice and policy relevance began with my experience working as an epidemiologist during the SARS outbreak in Toronto. After this experience I became very interested in pursuing further graduate training, particularly in public health surveillance. This experience, combined with a general interest in environmental health led to the development of my doctoral research topic. One of the aims of this work is to develop an innovative public health surveillance system for a key environmental health syndrome, heat-related illness, based on 911 ambulance dispatch data. Research into these kinds of systems, syndromic surveillance systems, is a rapidly-growing field, in both its actual implementation and methodological development. It has great potential as a tool for analysing health issues in a novel way, and for rapid detection of events. However, to date it has been used mainly for communicable diseases and bioterrorism. There has been very little exploration of its use for chronic or environmental conditions.

Heat-related illness is a growing concern, particularly for urban areas, and one which requires both rapid and longer term interventions. However, epidemiologic data on which to base policy-level interventions is currently limited, and sorely needed. My research aims to improve our understanding of heat-related illness at the population level, particularly in relation to the cross-section of high-risk populations and urban heat-islands. It is one of the first efforts to consider morbidity and includes a focused geographic component to identify local high-risk neighbourhoods for specific intervention in real-time. If it proves successful, it has the potential be a very practical new tool for urban health authorities and a great improvement on our current ability to monitor morbidity at a population level. Moving forward I plan to continue my research in this area, with a growing focus on the use of geospatial methods to identify populations that are vulnerable to the effects of environmental conditions, particularly those related to climate change.

My training in population and public health research has been guided by a team of wonderful mentors at the University of Toronto: my doctoral supervisor, Dr. Donald Cole, and advisory committee members, Dr. Elizabeth Rea, Dr. Wendy Lou, and Dr. Rahim Moineddin. In addition, attending the 2007 CIHR-IPPH Summer Institute provided valuable lessons in conducting population health intervention research in Canada and a unique opportunity to meet fellow student and faculty colleagues from across the country.

I feel very honoured to receive an award in memory of Dr. John Hastings, whose commitment to the education of public health students and professionals has had such a significant impact on public health in Canada.

Kate Bassil

Public Health in Canada:
Reducing Health Inequalities through Evidence & Action
Canadian Public Health Association
2008 Annual Conference

Halifax, Nova Scotia

In partnership with the:

Canadian Institute for Health Information –
Canadian Population Health Initiative

Canadian Institutes of Health Research –
Institute of Population and Public Health

National Collaborating Centres for Public Health

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FUNDING OPPORTUNITIES

IPPH is pleased to announce the following funding opportunities:

Operating Grant: Genetics (Ethics, Law and Society) - This RFA is designed to stimulate and promote research from many different disciplines into the ethical, legal and social issues relevant to population-based genetic research. Many of these issues remain under-explored, particularly in the Canadian context.

Around the world, population-based genetic research is fast emerging as an important area of investigation, and Canada is well placed to be a leader in this field. Our public health care system, the emergence of increasingly comprehensive health information databanks, our strong and vibrant genetics research community, and the existence of several unique populations combine to make Canada an ideal place to do this important work.

Meetings, Planning and Dissemination Grant: Global Health - The specific objective of this funding opportunity, announced through the Meetings, Planning and Dissemination Grants Program is to improve Canada's ability to investigate and intervene on those underlying forces that challenge global health, by exploring and establishing new collaborations with LMIC researchers to collaboratively develop and apply global health knowledge for evidence-informed policy and practice.

Partnerships for Health System Improvement - The purpose of this funding opportunity is to support teams of researchers and decision makers interested in conducting applied health services and policy research. IPPH and PHAC will contribute up to $300,000 to the following eligible research areas that link with a number of LfD III theme areas including Workforce planning, training and regulation; Governance and accountability; Managing and adapting to change; Linking public health and health services; and Sustainable funding and ethical resource allocation.

For more information on current funding opportunities, please visit our IPPH website at : www.cihr-irsc.gc.ca/e/13777.html

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